

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. ....

BIRTH NO. <u>49-107658</u>		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>481</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (If this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>THE CHILDREN'S MERCY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>14 EAST 27th</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>HUGH</u>		b. (Middle)		c. (Last) <u>Hitch</u>	
4. DATE OF DEATH		(Month) <u>JAN.</u>		(Day) <u>31</u>		(Year) <u>1949</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>1-18-49</u>	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months <u>13</u>	11. IF UNDER 1 YEAR Days	12. IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FAIRMOUNT Hospital; K.C., MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Hitch</u>		14. NAME OF HUSBAND OR WIFE <u>Billie Baxter, R.N. FAIRMOUNT Hosp.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NO.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Billie Baxter, R.N. FAIRMOUNT Hosp.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypoxemia of brain, lung &amp; G.I. tract</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>?</u> DUE TO (c) <u>?</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>173.0</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 21</u> , 19 <u>49</u> , to <u>Jan 31</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Jan 31</u> , 19 <u>49</u> , and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E.O.H. Schmidt</u> (Name of filer)				23b. ADDRESS <u>Hickman Mills Mo</u>		23c. DATE SIGNED <u>31 Jan 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb 4-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>Hickman Mills Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-2-49</u>		REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.D. Roehrer</u> ADDRESS <u>1415 E 15</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED FEB 26 1949

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.